The PREVENTION CONNECTION
NEWSLETTER

Legal Drugs: *Where it Begins*

—Dan Haffey

Twenty years ago, prevention in Montana was quite different than it is today. The approach taken back then by communities and agencies was about as diverse as the landscape in each of Montana's 56 counties. It was far from an exact science.

I can recall one situation, which took place in 1988. A young man of 19 decided that he had been bullied for the last time. He made a poor choice one afternoon while drinking alcohol, and the consequences could have included a long incarceration. I knew this young man and believed he was basically a good kid who had grown up with what we now call "a lot of risk factors." I asked the authorities and my supervisor if I could take a different approach with him. They were skeptical, but allowed me to take the young man to a ranch in the Big Hole Valley where he began work on a summer haying crew. I'd worked on that ranch in high school, so the owner was willing to give it a try. I still receive Christmas cards from that young man. He's now in his 30s, and still living and working on that ranch in the Big Hole Valley. He is married and has a daughter. He has also started a recovery group and a Bible study group with his neighbors. I believe in outcomes. I can only hope and pray for more.

There have been other times that I've seen firsthand just how destructive substance abuse can be in young people's lives. In my early years as a chemical dependency counselor, I facilitated educational groups at Montana State Prison. I learned as much as I taught during those sessions.

One of my first groups at the prison was made up of about a dozen inmates, all of whom were housed in a high security or closed unit. I was in my early 30s and feeling uneasy about sitting in a room alone with twelve felons when I nervously asked them to give information like their names, age, where they were from and why they were there. I remember three things about that group that I will never forget.

(1) Over half were there for a violent crime such as assault or homicide.

(2) They had all been using some type of drug at the time the offense was committed.

(3) I was the oldest person in the room.

Most of the group had little or no recollection of any type of prevention activities being offered in schools or communities when they were growing up, although a couple had a seen the film *Red Asphalt on the Highway* prior to getting their drivers' licenses. Alcohol and marijuana were the drugs of choice during this era, though a few had experimented with LSD, cocaine and mushrooms. A couple had used inhalants. All had used tobacco products.

The drugs of choice among young people have remained somewhat constant in Montana and still include alcohol, tobacco, marijuana and inhalants. Young people are much more prone to addiction than older individuals whose bodies and brains are mature and thus somewhat better able to handle the chemicals. We now realize that brain development is adversely affected by alcohol, and I firmly believe

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Alcohol, Tobacco and Other Legal Drugs

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604
Web Site: www.prevention.mt.gov

Director
Vicki Turner
(406) 444-3484
vturner@mt.gov

VISTA Leaders
Stephanie Knisley
(406) 444-3925
Sknisley@mt.gov

Greer Gurganus
(406) 444-9655
Ggurganus@mt.gov

Ernie Chang
PRC Technician
(406) 444-9654
echang@mt.gov

The Prevention Connection

Sherrie Downing
Editor
(406) 443-0580
Fax: (406) 443-0869
E-mail: DowningSL@bresnan.net
www.sherriedowning.com

Karen von Arx Smock
KD Graphics
Freelance Design & Production
Phone/fax: (507) 894-6342
E-mail: kdgrafix@acegroup.cc

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The Vicki Column: *Hiding in Plain Sight*

It's hard to escape: beer ads on billboards at sporting events, liquor ads on television, cigarette companies paying millions for subliminal messaging that includes use of their products in high-profile movies. This kind of advertising is so pervasive that it's hiding in plain sight, easy for adults to miss. Unfortunately, kids don't.

The alcohol industry spends more than $1 billion on advertising each year. The National Institute on Children and the Family estimates that teens will see approximately 75,000 ads for alcohol by their 16th birthdays. The problem is that several studies link alcohol advertising to children's beliefs about drinking. Those who are more aware of television beer commercials have more favorable attitudes toward drinking, greater knowledge of beer brands and an increased intent to drink as adults.

Drinking isn't the only thing we need to worry about. Dextromethorphan reduces coughs when used properly and has effects similar to those of phencyclidine (PCP) when used in large quantities. Inhalants are common, readily available and inexpensive. Prescription drugs can be as close as a parent's medicine cabinet. We've highlighted 2004 Montana Prevention Needs Assessment data on pages 16 and 17. It's worth taking a look at the patterns of use of alcohol, tobacco, inhalants and opiates among our youth in grades 8, 10 and 12. Nearly 85 percent of 12th graders had used alcohol during their lives; almost 19 percent had tried opiates. More than 15 percent of 8th graders had used inhalants.

There is no way we can ensure that kids won't be tempted. In fact, we can be pretty certain that they will be, probably on a daily basis. As parents, teachers and prevention professionals, we can't spend a billion dollars a year to inundate the media, but we do have science-based prevention on our side. We know how to help youth resist temptation. We can practice good, two-way communication. We can be vigilant for danger signs and promote healthy alternatives. And we can quit looking past dangers hiding in plain sight.

– Vicki

P.S. Please see the pull-out resource in the center of this issue of the *Prevention Connection*. It's packed with information about some of the legal drugs discussed in this issue.

A Leap in Prescription Drug Abuse

A new study from the National Center on Addiction and Substance Abuse (CASA) at Columbia University reveals the findings of a three-year study of prescription painkillers, depressants and stimulants. The study revealed that the 15.1 million Americans abusing prescription drugs exceeds the number abusing cocaine, hallucinogens, inhalants and heroin combined.

While the U.S. population increased 14 percent from 1992 to 2003, the number of 12-17 year-olds abusing prescription drugs jumped 212 percent and the number of adults doing so rose 81 percent. The total number of Americans abusing prescription drugs went from 7.8 million to 15.1 million during that time.

Additional information from the CASA study shows that teens who abuse prescription drugs are twice as likely to use alcohol, five times likelier to use marijuana, 12 times likelier to use heroin, 15 times likelier to use Ecstasy, and 21 times likelier to use cocaine, as compared to teens who do not abuse such drugs.

For more details on the recent study from the National Center on Addiction and Substance Abuse log on to www.casa columbia.org.

Governor's Column: *A Vision of HOPE*

—Governor Brian Schweitzer

Bringing *HOPE* to all Montanans—from the last and the least to the first and the most—is a foundation of my administration. In offering *Healthy* options and *Opportunities* that *Promote Economic* self-sufficiency, it is my belief that we will provide the best for our children.

As a state, we must create healthy options for everyone. Unfortunately, many of our most vulnerable citizens are lacking the health care they desperately need. Affordable and accessible health care for kids and families translates into action that makes a difference in people's lives. Some real steps were taken in the 2005 Legislative Session to support small business to access affordable health insurance for their employees and funds to get more kids on CHIP.

HOPE is a core principle of prevention. Rather than trying to decide what to do when our kids drop out of school or become addicted to drugs or alcohol, we need to take proactive steps to help our youth before problems begin. For example, meth is a scourge on our communities, but it is rarely a first step. Instead it is usually the end of a long road that starts with tobacco and alcohol. No one wakes up one day and decides to live in extreme poverty or to become homeless. That, too, is the culmination of a long downhill slide that often starts with lack of *HOPE* and opportunity. I have no doubt that by working together, we can stop many problems before they start and that together we can provide positive opportunities for healthier communities that strengthen families and build *HOPE*.

Leadership to Keep Children Alcohol Free

Montana's First Lady, Nancy Schweitzer, has joined the national Leadership to Keep Children Alcohol Free, a unique coalition of governors' spouses, federal agencies, public and private organizations. This is an initiative to prevent the use of alcohol by children ages 9 to 15 and is the only national effort that focuses on alcohol use in this age group. The initiative was founded by the National Institute on Alcohol Abuse and Alcoholism and the Robert Wood Johnson Foundation, and has been joined by additional federal sponsors.

This is a particularly important initiative, in part because:

— Research indicates that adolescents who abuse alcohol may remember 10% less of what they have learned than those who don't drink.

— In SAMHSA's 2003 National Survey on Drug Use and Health, persons reporting first use of alcohol before age 15 were more than five times as likely to report past year alcohol dependence or abuse than persons who first used alcohol at age 21 or older.

Source: www.alcoholfreechildren.org

"I chose to join the Leadership to Keep Children Alcohol Free initiative because I am deeply concerned about the devastating effects, both short- and long-term, of alcohol on our nation's youth."

—Nancy Schweitzer

Interagency Coordinating Council (ICC)

Mission: To create and sustain a coordinated and comprehensive system of prevention services in the State of Montana.

Prevention Resource Center
P.O. Box 4210
Helena, MT 59604
(406) 444-3484
(406) 444-4435 (Fax)

ICC Chair: ***Roland Mena***
Executive Director
Montana Board of Crime Control

Members

Joan Miles
Director
Department of Public Health and Human Services

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Where it Begins

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that alcohol, tobacco, marijuana and inhalants are gateways to much harder drugs. To pass them off as not all that serious is denying that we have a problem.

Unfortunately, the rite of passage attitude is alive and well. Our youth fatality rates for alcohol-related crashes and suicide are some of the highest in the nation. The ripple effect of substance use and abuse affects every resident of this state. Our jails are full; our healthcare facilities feel the added pressure and our treatment centers have people lined up to get in. Incarceration without treatment is not the answer. Longer and more intensive programs are needed. Social norms need to change and we need legislators to provide for treatment needs.

Prevention

Prevention in Montana is quite a different story today than it was when I was learning from the prisoners' group. Even though the problems with substance abuse were not that much different than those we deal with today, the methods to facilitate change have evolved dramatically. We are now at the forefront of prevention. Innovative strategies and activities begin as early as preschool and continue into college and adulthood. Collaborative efforts through agencies like the Addictive and Mental Disorders Division and the Montana Tobacco Use Prevention Program are showing positive outcomes through the use of science-based prevention. Risk and protective factors are being addressed, and both play integral roles in whether or not youth will use substances.

Many other programs also assist in Montana prevention, including Safe Kids Safe Communities, County DUI Task Force Coalitions, Big Brothers Big Sisters, Boys and Girls Clubs and many, many others. All are offering positive alternatives to Montana's children. Our schools are also active in collaborating with the various agencies to provide positive prevention programs. Because teens represent one of the largest buying groups in our economy, we teach media literacy to show students how they are being targeted by tobacco and alcohol companies.

Despite the fact that our state has a serious problem with methamphetamine, I have never met anyone whose first drug was meth. The Attorney General and Office of Public Instruction are working with communities and schools across Montana to educate and provide community awareness of this devastating drug. Butte Silver Bow County Health Department has made the Meth Free Montana, Meth Watch program a priority and has involved the entire community in this ongoing effort. One individual has stepped up and donated millions of dollars to a new media campaign to educate Montanans about this drug. This campaign presents a dramatic and poignant look into how devastating this drug can be.

While many of us working in prevention throughout Montana feel that progress is being made and outcomes are being achieved, the battle is far from won. We continue to look at new programs that address pre-addiction. Two good examples are pilot programs being tested in Butte and Bozeman. They offer brief screening and interventions with the help of multiple community resources. These agencies use a screening tool, which addresses individual alcohol abuse in the early stages with the goal of preventing addiction.

Every resident of Montana is being affected by legal as well as illegal drug use and abuse. It is going to take all of us to create lasting change in our communities and state. Positive prevention is providing hope. As long as we continue to work together, we will continue to see progress.

—Dan Haffey is a state certified teacher, licensed addictions counselor and prevention specialist with the Silver Bow County Health Department. He has more than 20 years experience in these arenas and has been active in helping develop legislation relating to Minors in Possession and tobacco clean indoor air laws. He has most recently helped develop the Meth Free Montana and Meth Watch programs in Butte.

Did you know?

—The death rate for Montana teens (aged 15 to 19) from accidents, homocide and suicide was 81 per 100,000 compared to 51 per 100,000 nationally.

—8% of Montana high school students reported using methamphetamines in their lifetimes.

—Slightly over half (55%) of Montana high school students have tried smoking.

—In 2005,15% of Montana high school students reported using chewing tobacco. This figure was two percentage points higher than in 2003.

—23% of Montana 7th and 8th grade students had at least one drink of alcohol during the 30 days prior to the survey. Of those students who had a drink of alcohol, 23% were less than nine years old when they had their first drink.

Source: Youth Risk Behavior Survey, 2005

Notes From the Edge
Jaylene: *a Success Story*

I was 13 when I started using alcohol and drugs. I grew up in an alcoholic home, so I learned fast. I first got mixed up with the law when I got alcohol poisoning. I got six months probation that eventually turned into five years, but I kept using. Soon I was failing in school, failing my urinary analyses . . . and my family life was slipping fast. I was tired of pretending everything was all right when it was far from all right. I was drinking and smoking weed, and cutting myself.

The first time I got sent away, everyone thought I had mental problems. Maybe I did—I had a huge problem with self harm for a while. But that's where I learned which pills to mix to get a really good high. Nobody took their medications: they "cheeked" them to trade later. While I was there, I got my Ph.D. in *Pharmaceuticals*.

When I got home, it was the same old story, but I wasn't really expecting anything different. My mom was drinking, my dad was always working and my brother stayed gone. I got thrown into jail a couple of times and was in and out of school. I left my house for a while and moved to Havre with a foster parent, because the judge said my problem was in my environment, not my mental state.

Havre was a bigger playground with different playmates. Unfortunately, they were all drug dealers. I kept sneaking out until my foster parents put an alarm on my windows and door. I learned to bypass that, too. After my foster mother found a bottle of Jack Daniels and some weed hidden in my room, my probation officer sent me back to my mother. I was back in jail in no time. By this time, I had graduated to a Ph.D. in *Manipulation*. When I went back in front of the judge, he said my issues weren't mental or environmental, but behavioral. He sent me to an outdoor treatment program.

This time when I got home, it wasn't the same old story. My mom and dad had broken up and everything had finally blown to hell. I'd known it was coming, but somehow I still wasn't expecting it. I got drunk my first night home and once again found myself in jail. Nobody knew what to do with me. By that point, I didn't know what to do with myself or with my life.

They sent me to live with my grandmother. I smoked weed every day and drank every night. I started smoking meth. I was spun out of my mind when I stole a car and took it off a forty-foot drop, in the process messing up my back and shoulder. I got out of the car, walked to my cousin's house and caught a ride back in time for school. When the cops caught up with me at school, I was coming down from the drugs and starting to feel the pain of the wreck. Of course I went to jail. After that, I swore I wasn't going to do meth again and I didn't, but that wasn't the end of my drug career, not yet.

When they released me from jail, they put me on an ankle monitor. I was still drinking and doing drugs. I didn't care if I lived or died. Sometimes I wished I would have just cracked my spinal cord when the car rolled, but apparently God had different plans for me. This time, I got sent to North Carolina for treatment. When I got back, I knew I couldn't live near the Hi-line if I wanted to stay out of trouble. I asked to move to Billings, and went into shelter care.

The night before I went to see the judge about stealing the car, I got wasted. I went to court on November 9th, with a hangover. The judge said he'd done everything he could to help me. It was then that I realized I didn't want to do this anymore. I was tired of being who I was.

About this time, I found out I was pregnant with my son, Lucas. My mom was in prison and my dad was working up north. All of my family was on the Hi-line. I was alone, 17, homeless and pregnant. I was a high school drop-out without a job. I felt worthless and my body was changing. That's when Tumbleweed's First Step House took me in. I was surprised because no one else would.

I knew I had to sink or swim. My life wasn't just my life anymore. I started going to A.A. and working a program. Everyone in the house supported me. When I moved out on my own, it was a whole new experience. For five years, I'd been in and out of institutions, surrounded by people. I was sober, but I was lonely and alone. To make matters worse, I was worried about my image and my social skills were terrible. I had been using for so long that I never learned how to interact with people unless we were using together. The stress was terrible, but I didn't use.

The street outreach people from Tumbleweed worried about me. One of the staff, Nicole, would come see me and take me grocery shopping because I didn't have a way to get around. After some time and help from Nicole, I started to become more involved in A.A. That's when I met my boyfriend, Mike. We started dating in April. He asked me to move in with him before I had the baby, so I did. Nicole and Chris from Tumbleweed helped me move, and I don't know what I would have done without them. I had Lucas on July 4th. He weighed 6 pounds 5 ounces and was 20 inches long.

These days, things are wonderful. I have a boyfriend who takes care of me and loves me, a home and a beautiful little baby boy. I'll be sober one year on November 9, 2005. Now, finally, I am happy. Really happy. I have earned my Ph.D. in *Being a Mother*, a good mother.

Jaylene

The mission of Tumbleweed Runaway Program, Inc. in Billings is to address the immediate needs of runaway, homeless and at-risk youth and their families. Tumbleweed provides counseling services, temporary shelter, mediation, advocacy, independent living, street outreach and referral to community resources. For more information, contact Executive Director, Sally Leep at (406) 259-2558.

On the Frontier: *Youth Alcohol Use*

—Tim Anderson

Working in the vast state of Montana and having spent most of my time in the farther reaches, I have noted a variety of populations to be served in Montana. There are some special challenges in serving each population, but when you look at the Prevention Needs Assessment data, it reveals that binge drinking and thirty (30) day use is approximately ten percent higher in frontier communities than the state average.

There are specific risk and protective factors that are higher in frontier counties versus the more populated counties in Montana. Some that stand out include: parental attitude related to alcohol and drug use; rebelliousness; rewards for anti-social behavior; and low commitment to school.

The lack of protective factors that appear to contribute to this issue are: lack of opportunities for pro-social involvement; lack of opportunities for family and school domains; and low belief in a moral, social order.

There are characteristics specific to rural areas that may help explain the differences and that contribute to the combined palette of risk and protective factors.

Living in small rural areas means having one peer group. Either a youth fits in with that group, or s/he does not. It would be difficult to find an alternative group to spend time with. If a small number of a certain youth population begins to use alcohol and drugs, it becomes the thing to do. Others tend to follow suit in what may amount to an *all or nothing* peer group. At the same time, alcohol use is seen as a right by most youth as well as by a lot of the community. The attitude prevails that if you work hard, you can play hard and drink hard. This is evidenced by alcohol use at brandings, harvest time, and other local social events.

Another issue that contributes to accepting attitudes toward alcohol and drug use in rural areas is that often the local bar is the only gathering place for social and community activities. In small communities, the bar, grocery store and café may be one and the same. What this means is that youth are exposed to alcohol at earlier ages, and that they are exposed to bars, become familiar with bars, and with drinking behavior. They see more adults engaging in alcohol consumption. Youth are more likely to become involved with alcohol use after being exposed to it within their families and in the community at an early age.

When we ask youth why they drink, they invariably say there is nothing else to do. Although we know that is not necessarily one of the primary factors in their chemical use, this excuse is truly more valid in small towns than in larger population areas. In some small towns, going to the local bar to play pool or video games provides the single source of recreational activities outside those that are self-generated.

Many people who live in frontier areas are involved in agriculture and farming. These populations are known for their independence. Sometimes youth interpret this independence as rebelliousness and model that behavior with their own rebellion, but without the social constraints to appropriately modify that tendency.

Youth who are involved in alcohol and other risk behaviors are sometimes rewarded for their rebellion. Often, as mentioned earlier, youth will take on an identity, basing some of that identity—and behavior—on the mythology of previous classes or groups of youth. There is often, if not always, an attempt to match or beat drinking prowess noted in the local mythology.

As far as protective factors go, there is often a lack of opportunity for pro-social involvement because of the limited number of activities youth can be involved in. Since a high percentage of youth are involved in agriculture, they already have fairly busy schedules. Because being involved in the community and doing good things is part of the community norm, oftentimes youth are not recognized for their pro-social involvement as much as they might be in another environment.

Change can be somewhat more difficult in rural areas because the access to services and the number of people working toward making change are limited. Many frontier counties only have visiting professionals. Those professionals come from various agencies and may be available on a limited basis—sometimes as little as half a day a week or every other week. The distrust of outsiders can make it even more

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Monitoring the Future: 2004

Inhalants, as a class of drugs, showed clear evidence of increase in 2004, particularly among 8th graders. The annual prevalence of inhalant use by 8th graders rose by a statistically significant one percentage point, from 7.7% to 8.7% in 2003 and then to 9.6% in 2004. In 2004 there was some (not statistically significant) increase in grades 10 and 12, as well. These increases are noteworthy primarily because they reflect a turnaround from a long period of sustained declines in use at all three grade levels, including a 40% decline in annual prevalence among the 8th graders between 1995 and 2002. (www.monitoringthefuture.org)

While the rates of Vicodin abuse did not change significantly from 2003 to 2004, Vicodin was used by 9.3% of 12th graders, 6.2% of 10th graders and 2.5% of 8th graders in the past year. OxyContin was used in the past year by 5% of 12th graders, 3.5% of 10th graders and 1.7% of 8th graders in 2004. These rates were not significantly different from the rates in 2003, but when all three grades were combined, there was a significant increase in past year OxyContin use between 2002 and 2004.

Source: www.nida.nih.gov/Newsroom/04/NR12-21.html

Youth Alcohol Use

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difficult to impact small frontier communities. Another issue of concern is basic access in terms of travel time to become involved in activities.

At the same time, some of the benefits, rewards and opportunities of rural communities are also the problems. We are dealing with small populations, so impacting a few people will make a more significant change. Just as they only have one peer group practicing negative behaviors, there can be one peer group practicing positive behaviors. There is more continuity and less transition in these communities, making it possible to sustain and build on progress you have made. It is usually easier to have access to youth because there are not as many demands for their time in school. There is a high level of ownership and pride, and a desire for the community to sustain itself. Community members are willing to engage and be involved in the process of making the community healthier for youth.

These are special challenges in trying to provide treatment and prevention services in frontier counties. I would love to say I have developed a solution to resolve these issues, however, if I had, I would be on Oprah selling my book, and not in the middle of writing an article for the *Prevention Connection.* I am always open to feedback on how other people are solving and resolving the issues in their frontier communities, and encourage people to begin developing forums to communicate specific ways to address these issues in the frontier areas in Montana.

—Tim Anderson is the Clinical Director for the District II Alcohol and Drug Program in Sidney.

The Blank Zone

—Dr. Richard Wise

—It never ceases to amaze me what lengths people will go to find new substances to abuse—both legal and illegal. People can be very creative. —Dr. Wise

Inhalant use is up. I've seen it among my patients at Pathways, and the *2004 Monitoring the Future Survey* confirms it at the national level. Although there is a downward trend in drug abuse among adolescents in general, the use of painkillers—opiates such as Lortab, OxyContin and Vicodin—is also up.

The 2004 *Prevention Needs Assessment*, administered by the Addictive and Mental Disorders Division, revealed a general downward trend for inhalants in Montana, and yet 15.5 percent of 8th graders had used inhalants at some point in their lives. What I'm hearing from my patients is that Dust-Off is a favorite. They call it *dusting.* The inert gas in this product blocks oxygen in the airway. Kids are dying from this stuff. Kids are using this in Montana, and it's extremely dangerous. One study done in the United Kingdom revealed that 39 percent of deaths resulting from the use of Dust-Off occur the very first time a kid uses it. Of course, Dust-Off isn't the only inhalant that's a problem. Kids are telling me about using rubber cement, WD-40, stainless steel cleaner, Glade, Lemon Pledge, Mr. Bubbles, fingernail polish remover and gasoline. What they say is that they do it to "feel weird and numb." Inhalants will certainly do that for them. Inhalants distort reality, making things look and feel weird.

The long-term effects of inhalants are really frightening. Since they are hydrocarbons, they pass directly through the blood/brain barrier. Alcohol, on the other hand, is absorbed from the blood and ultimately gets pumped to the brain. Inhalants are lipid soluble, so they go directly to the brain. This can cause damage that includes permanent memory, attention and learning problems.

Another category of readily available perceptual distorters are over-the-counter cold medicines. Some contain Dextromethorphan. Slang names include Dextro, Robo DM or Robo Fry. Robitussin DM is commonly sold in eight ounce bottles. One young man reported drinking two at a time, then another every four hours to "keep the fry going." Unfortunately, in this case, *frying the brain* is a pretty accurate description of what's happening. Other abusable substances are cold medicines in pill form. Coricidin is a favorite—young people call it *Triple C* for Coricidin Cold and Cough. One teen reported taking 30 Coricidin tablets at a time. "I can't see, I get slurred speech, I feel numb and weird." Kids also take Dramamine in extremely high doses, seeking the "Blank Zone."

Teens will also abuse prescription drugs such as OxyContin, Lortab and Vicodin. I haven't had an adolescent with a primary diagnosis of opiate dependence, but they're not afraid of these drugs. One limitation to teen opiate abuse is their high cost: $10 – $45 per pill.

In addition to the dangers listed above, substances such as inhalants and cold medicines pose one final problem. If teens are willing to "distort reality" with these drugs, they often move on to other abusable and potentially even more harmful substances. This is a gateway drug concept, and a present and real danger.

Blackout—*a "Game" With Deadly Consequences*

Montana youth could be putting their lives at risk if they play a dangerous fainting game often called "blackout." The game—also known as suffocation roulette, space monkey, pass-out, knock-out, or flatliner—can cause brain damage, disability, and even death.

"This game isn't new," said Wilda McGraw, a public health nurse consultant with the Montana Department of Public Health and Human Services (DPHHS). "It's been around for decades and is fairly popular with risk-taking kids who think they can control the outcome. Fatal cases may mistakenly be ruled as suicides by coroners who are unfamiliar with the game."

McGraw, who heads the state Fetal, Infant and Child Mortality Review (FICMR) team at DPHHS, said local FICMR teams have identified the fainting game as a potential problem.

"According to one county FICMR coordinator, they just had a situation in their school last spring where children 10 to 12 years old were choking each other until they passed out," McGraw said. "It was a big thing at some slumber parties the kids were having. The school held an assembly to try to inform parents and children how dangerous this can be."

McGraw also noted that there have been two deaths in Idaho in the past few months of children who may have been playing the asphyxiation game.

The game usually involves at least two children. One takes a deep breath and holds it while a partner squeezes off the circulation to the first child's brain, either manually or with a rope, leash or similar device. When the first child starts to lose consciousness due to oxygen deprivation, the partner releases the pressure, allowing the blood to rush to the brain. This supposedly causes a sense of euphoria. The game is even more dangerous when played alone.

"Strangulation deaths can be the all too tragic result, since no one is around to come to the rescue if the player miscalculates," McGraw said.

According to some professionals, children who avoid drugs and alcohol may be more susceptible to engaging in this activity. They may mistakenly believe that the game is good, clean fun and gives them a "natural high."

"The fact is, there's only a short period of time that brain cells can function without oxygen before irreversible damage or death," McGraw said. "This is a dangerous game, and parents need to talk to their children about the danger of playing it."

Some warning signs that a child is playing the game are frequent headaches and unusual marks or bruising on the neck.

For more information, contact Gayle Shirley, Public Information Officer, DPHHS, at 406-444-2596.

The Alcohol Risk Continuum

1. People who ***abstain*** are those who consume no alcohol.
2. ***Low-risk*** drinkers are those who consume alcohol at or below the American Medical Association's recommendations (see below). A person drinks at low-risk levels if they experience no negative consequences as a result of their alcohol consumption. Some people will stay in this stage indefinitely.
3. ***At-risk*** or ***hazardous*** drinkers are those who drink alcohol at amounts above those recommended by the American Medical Association. "Risky drinkers" are people who may or may not have experienced a negative consequence or two.
4. ***Alcohol abusers*** have experienced repeated alcohol-related negative consequences such as accidents, injuries, problems in school, behavioral problems, blackouts, abusive behavior, fines by police, visits to the emergency room or urgent care center. The main difference between risky use and abuse hinges on negative consequences—if the person has experienced repeated negative consequences, yet continues drinking, s/he is considered to be in the abuse stage.
5. ***Dependent drinkers*** are defined as those who are unable to control their alcohol use, have experienced repeated adverse consequences, are preoccupied with alcohol use, and may have evidence of physical tolerance or withdrawal. Even at this stage, alcohol or other drug use may not yet be compulsive and out of control. Many dependent drinkers are able to work, maintain family relationships and friendships, and limit their use of alcohol or other drugs to certain time periods, such as evenings or weekends.

The American Medical Association and various other medical professional organizations offer the following recommendations regarding alcohol use:

- Men should drink no more than 14 standard drinks per week, and no more than 3-4 at a single occasion.
- Women should drink no more than 7 standard drinks per week, and no more than 2-3 at a single occasion.
- Senior citizens should drink no more than one standard drink per occasion.
- Pregnant women, and people under age 21, should not consume any alcohol.

Source: Richard Brown, MD, physician and professor at the University of Wisconsin School of Medicine. For more information, go to www.projectmainstream.net. Select Resources, then Mainstream Syllabus.

An Illusion of Safety

Compared to other commonly abused drugs, such as heroin and crack cocaine, prescription drugs are unique in that they can be obtained through legal channels. These drugs have become attractive to would-be substance abusers because they are manufactured legitimately and prescribed by physicians, giving them the illusion of safety. In reality, the addiction and withdrawal associated with the abuse of many prescription drugs can be more harmful than that associated with some illegal drugs.

If physical dependence is present and a person suddenly stops taking a prescription drug, such as Xanax, there is a high risk of seizures or even death. Physical dependence, however, is not necessarily an indication of addiction. It simply means that the body has developed a tolerance and the user cannot stop taking the drug without gradually decreasing the dose in order to prevent withdrawal. The legitimate need for these drugs and the demand for them by substance abusers and addicts are opposing issues that have to be addressed together in order to make them available while preventing their abuse.

This is particularly the case with prescription pain relievers. Because of drugs like OxyContin, individuals with severe, long-term pain no longer have to suffer. The people who have legitimate need for these medications are not typically the same people who become abusers. Research indicates that someone with no history of addiction seldom becomes addicted to his or her prescribed medications.

The illegal use of prescriptions drugs takes lives, and hundreds of deaths have been attributed to overdoses of oxycodone, the main ingredient in OxyContin and Percocet. Many deaths have also been attributed to overdoses of the prescription pain medications oxycodone and hydrocodone, as found in brand name drugs Vicodin and Lortab. Prescription drugs are often easier to obtain than illegal drugs. The Internet contributes to this problem through the hundreds of web sites selling prescription drugs without a prescription.

Prescription drug diversion is the deflection of prescription drugs from medical sources into the illegal market. The exact amount of prescription medications diverted is unclear, but a 2001 survey of 34 law enforcement agencies reported 5,802 cases of diversion in 2000 alone. Prescription drugs can be a lucrative business, selling on the street for as much as 10 times what they are worth retail. An 80 mg OxyContin pill, for example, costs about $6 at a pharmacy and sells for $65 to $80 on the street.

Due to the ease of obtaining prescription drugs and the common misconception that they are "safe" to abuse, the trend of prescription drug abuse by our nation's youth is steadily increasing.

The stimulant Ritalin is also often used with other drugs and/or alcohol. Reports of Ritalin abuse are becoming more common, especially among college students. One study found that one-fifth of college students interviewed had taken Ritalin at least one time. Campuses all over the country report that these drugs are as common as marijuana and are heavily relied upon for late-night studying.

Methods of Diversion

While youth typically acquire drugs by stealing from their relatives or buying from classmates who sell their legitimate prescriptions, the diversion of prescription drugs among adults typically occurs through:

- doctor shopping;
- illegal Internet pharmacies;
- drug theft;
- prescription forgery; and
- illicit prescriptions by physicians.

Source: Pilar Kraman: Drug Abuse in America—Prescription Drug: Trends Alert. Council of State Governments. 2004. www.csg.org/CSG/Products. Go to *Trends Alerts*, then *Prescription Drug Diversion.*

Behavioral cues for alcohol consumption appear progressively in four basic areas.

1. Inhibitions
- *Becoming overly friendly*
- *Bravado*
- *Becoming loud*
- *Changing from loud to quiet or vice versa*
- *Drinking alone*
- *Annoying other customers*

2. Judgment
- *Complaining about strength of drink*
- *Changing consumption rate*
- *Ordering doubles*
- *Becoming argumentative*
- *Using foul language*
- *Careless with money*
- *Buying rounds for strangers or buying rounds for the "house"*
- *Making irrational statements*
- *Becoming belligerent*

3. Reactions
- *Lighting more than one cigarette at a time*
- *Unable to light cigarette*
- *Glassy eyes, lack of eye focus*
- *Loss of train of thought*
- *Slurred speech*

4. Coordination
- *Unable to pick up change*
- *Spilling drink, can't find mouth with glass*
- *Unable to sit straight on chair or barstool, swaying, drowsy*
- *Stumbling, has trouble moving around objects in path, bumps into things*
- *Falling*

Source: Alcohol Sales and Underage Drinking Laws in Montana is published and distributed by the Montana Department of Transportation. This useful 24-page brochure provides an exceptional overview of drinking laws and can be accessed by contacting

Dust-Off: *a True Story*

June 3, 2005

Editor's note: This story has been widely distributed and printed on the internet, and has been verified by truthorfiction.com. The original e-mail is a long letter from a grieving father warning others about the potentially lethal effects of inhaling the compressed air product, Dust-Off. The e-mail describes the death of his 14-year-old son, Kyle. The "Jeff" of this email is a police officer from Painesville Township, Ohio. His son Kyle died in March 2005.

First, I'm going to tell you a little about me and my family. My name is Jeff. I am a police officer for a city known nationwide for its crime rate. We have a lot of gangs and drugs. At one point we were # 2 in the nation in homicides per capita. I have a police K-9 named Thor. He was certified in drugs and general duty. He retired at three years old because he was shot in the line of duty. He lives with us now and I still train with him because he likes it. I always liked the fact that there was no way to bring drugs into my house: Thor just wouldn't allow it. The reason I say this is so you understand that I know about drugs. I have taught in schools about drugs. My wife asks all our kids at least once a week if they have used any drugs and makes them promise they won't.

I like building computers and started building a new one in February 2005. I was also working on some of my older computers. They were full of dust, so on one of my trips to the computer store I bought a three-pack of Dust-Off, compressed air to blow dust off a computer. A few weeks later when I went to get them, they were all used. I talked to my kids and my sons said they'd used them on their computers and messed around with them. I yelled at them for wasting the $10 I'd paid. On February 28, I went back to the computer store. They didn't have the three-pack that I had bought on sale, so I bought a single jumbo can of Dust-Off. I went home and set it down beside my computer.

On March first, I left for work at 10 P.M.. At 11, my wife went down and kissed Kyle goodnight. At 5:30 the next morning, she went downstairs to wake Kyle for school. He was sitting up in bed with his legs crossed and his head leaning over. She called to him a few times to get up. He didn't move. He would sometimes tease her like this and pretend he had fallen asleep again. Kyle was never easy to get up, so Kathy finally went in and shook his arm. He fell over. He was pale white and had the straw from the Dust-Off can coming out of his mouth and the new can of Dust-Off in his hands. Kyle was dead.

I am a police officer and I had never heard of this. My wife is a nurse and she had never heard of this. We later found out from the coroner, after the autopsy, that only the propellant from the can of Dust-Off was in his system. No other drugs. Kyle had died between midnight and 1 A.M.

I found out that using Dust-Off is being done mostly by kids ages 9 through 15. They call it *dusting*. It gives them a slight high for about 10 seconds—it makes them dizzy. A boy who lives down the street from us showed Kyle how to do this about a month before. Kyle showed his best friend. Told him it was cool and that it couldn't hurt you because it was just compressed air. His best friend said *no*.

Kyle was wrong. It's not just compressed air. It also contains a propellant called difluoroethane. It's a refrigerant like that used in your refrigerator. It is a heavy gas. Heavier than air. When you inhale it, it fills your lungs and keeps the oxygen out. That's why you feel dizzy, buzzed. It decreases the oxygen to your brain, to your heart. Kyle was right. It can't hurt you—*it kills you*.

The horrible part about this is there is no warning. There is no level that kills you. It's not cumulative or an overdose; using can just go randomly, terribly wrong. Roll the dice and if your number comes up you die. *It's not an overdose*—it's Russian Roulette. You don't die later. Or not feel good and say, "I've had too much." You usually die as you're breathing it in. If not, you die within two seconds of finishing "the hit." That's why the straw was still in Kyle's mouth when he died. Why his eyes were still open.

The experts want to call this huffing, but the kids don't believe it is. As adults we tend to lump many things together. But it doesn't fit here. There is no chemical reaction, no strong odor. It doesn't follow the huffing signals.

Kyle complained a few days before he died of his tongue hurting. It probably did. The propellant causes frostbite. If I had only known.

It's easy to say *hey, it's my life and I'll do what I want*. But it isn't. Others are always affected. This has forever changed our family's life. I have a hole in my heart and soul that can never be fixed. The pain is so immense I can't describe it. There's nowhere to run from it. I cry all the time and I don't ever cry. I do what I'm supposed to, but I don't really care.

My kids are messed up. One won't talk about it. The other will only sleep in our room at night. And my wife—I can't even describe how badly she is taking this. I thought we were safe because of Thor. I thought we were safe because we knew about drugs and talked to our kids about them.

We need to get this out of our homes and school computer labs. Using Dust-Off isn't new and some professionals do know about it—it just isn't talked about much, except by the kids. They know about it.

April 2nd was one month since Kyle died. April 5th would have been his 15th birthday. And every weekday I catch myself sitting on the living room couch at 2:30 in the afternoon, and waiting to see Kyle get off the bus. I know Kyle is in heaven, but I can't help but wonder if I died and went to Hell.

—Jeff

For more information:

- Dust-Off is from Falcon Safety Products, which has posted a warning about misuse of Dust-Off at: www.falconsafety.com
- Dust-Off is just one of numerous products used by those involved in "inhalant abuse." Go to the National Institutes of Health at: www.nida.nih.gov/ResearchReports/Inhalants/Inhalants.html

Mushrooms (Psychedelic)	
Description	Psilocybin and psilocyn are the hallucinogenic principles contained in certain mushrooms. Psilocybin is structurally similar to serotonin, and produces its effects by disrupting normal functioning of the serotonin system.
Method(s) of use	Mushrooms can be eaten, brewed and consumed as tea.
Effects	The high from using mushrooms is mild and may cause altered feelings and distorted perceptions of touch, sight, sound and taste. Other effects can include nervousness and paranoia. Effects can be different during each use due to varying potency, the amount ingested, and the user's expectations, mood, surroundings, and frame of mind. On some "trips," users experience sensations that are enjoyable. Others can include terrifying thoughts, anxiety, fears of insanity, death, or losing control.
Other names	Caps, magic mushrooms, mushrooms, psilocybin, 'shrooms
For more information	www.drugfree.org/Portal/Drug_Guide/Mushrooms www.erowid.org/plants/mushrooms/mushrooms_basics.shtml
Jimson Weed or Locoweed (Deliriant)	
Description	Jimson weed falls within the group of plants know as "belladonnas," perhaps due to the past use of Italian women to dilate their pupils for beauty purposes. Jimson Weed grows in Montana. It has been used for cold and asthma treatment, as well as religious purposes. The plant has been described throughout history as a toxin famous for its mind-altering properties. There are references to it in Homer's Odyssey, and Shakespeare's plays: Hamlet, Romeo and Juliet, and Anthony and Cleopatra.
Method(s) of use	Jimson weed can be ingested, made into a tea, and/or smoked as cigarettes. Some over-the-counter asthma preparations include jimson weed and can be abused. The plant and seeds are extremely toxic. This plant is abused as a hallucinogen in humans, and deaths in humans and animals have been reported.
Effects	Hallucinogenic and euphoric effects
Other names	Jimson weed (*datura stramonium*), locoweed, angel's trumpet, thorn apple, devil's trumpet, mad apple, stink weed, sacred datura, and green dragon
For more information	**Sources:** http://www.erowid.org/plants/datura/datura_info5.shtml
Peyote (Hallucinogen)	
Description	Peyote is a small, spineless cactus, Lophophora williamsii, whose principal active ingredient is the hallucinogen mescaline. From earliest recorded time, peyote has been used by Native people in northern Mexico and the southwestern United States as a part of traditional religious rites. Mescaline can be extracted from peyote or produced synthetically. Though peyote is used recreationally by some, it is relatively uncommon on the street.
Method(s) of use	Ingested; brewed into tea

Peyote, continued	
Effects	Once ingested, peyote can cause feelings of nausea before the desired mental effects appear, which are altered states of perception and feeling. Other effects can include increased body temperature, heart rate, blood pressure, loss of appetite, sleeplessness, numbness, weakness, and/or tremors. Effects can be different during each use due to varying potency, the amount ingested, and the user's expectations, mood and surroundings. On some "trips," users experience sensations that are enjoyable. Others can include terrifying thoughts, and anxiety, fears of insanity, death, or losing control.
Other names	Buttons, cactus, mesc, mescal, mescalito
For more information	www.drugfree.org/Portal/Drug_Guide/Peyote
Nitrous Oxide (Dissociative Anaesthetic Gas)	
Description	Nitrous Oxide is an aesthetic gas best known for its use in dentistry and as a whipped cream propellant. It is widely available and its effects are short lasting.
Method(s) of use	Nitrous is most frequently used in the form of whipped cream chargers, small metal cartridges which are 'cracked' either into a whipped cream canister or with a special 'cracker' into a balloon for inhalation. A single cartridge is between one and three lungs full of gas. One or two lung fulls is generally enough for a short nitrous experience although many people choose to use many cartridges throughout the course of a night.
Effects	Nitrous Oxide (N2O) is a simple gas that, when inhaled, causes rapid analgesia (pain relief), euphoria, mild sedation, and sometimes psychedelic dissociation. It has been used in dentistry since the mid 1800s and recreationally since the late 1700s when it earned the name 'laughing gas' because of its tendency to cause laughter in those who inhale it.
Other names	Laughing gas; cartridges; hippy crack; N2O
For more information	http://www.erowid.org/chemicals/nitrous/nitrous_basics.shtml http://www.erowid.org/chemicals/nitrous/
Steroids and Derivatives	
Description	Anabolic steroids are a group of powerful compounds closely related to the male sex hormone testosterone. Despite the fact that steroids are illegal unless prescribed, it is relatively easy to find steroids online. The price range for ingested steroids varies depending on the web site, product and amount. Most sites charge between $25 and $275 per bottle for ingested steroids, while injected steroids are usually cheaper, ranging from $12 to $190 per vial.
Method(s) of use	Steroids are taken orally or injected. Athletes and other abusers typically take them in cycles of weeks or months, rather than continuously. These patterns are called "cycling." Cycling involves taking multiple doses of steroids over a specific period of time, stopping for a period, then starting again. In addition, users frequently combine several different types of steroids to maximize their effectiveness while minimizing negative effects, a process known as "stacking."

Steroids, continued	
Effects	Reports indicate that use of anabolic steroids produces increases in lean muscle mass, strength, and ability to train longer and harder. The major effects of anabolic steroid use include liver tumors, jaundice, fluid retention, and high blood pressure. Researchers report that users may suffer from paranoid jealousy, extreme irritability, delusions, and impaired judgment stemming from feelings of invincibility.
Other names	Juice, 'roids, andro
For more information	http://www.drugfree.org/Portal/Drug_Guide/Steroids http://www.bodybuildingforyou.com/supplements-reviews/bodybuilding-supplement-reviews-2.htm
Cold Medicines (DXM) (Dissociative Anesthetic)	
Description	Dextromethorphan is a cough-suppressing ingredient found in a variety of over-the counter cold and cough medications. Like PCP and Ketamine, dextromethorphan is a dissociative anesthetic. Over-the-counter medications that contain detroxmethorphan (like Robitussin and Coricidin) often contain antihistamine and decongestant ingredients as well, and high doses of these mixtures can seriously increase the harmful effects.
Method(s) of use	Ingestion of pills or cough syrups
Effects	Common effects can include confusion, dizziness, double or blurred vision, slurred speech, impaired physical coordination, abdominal pain, nausea and vomiting, rapid heart beat, drowsiness, numbness of fingers and toes, and disorientation. DXM abusers describe different plateaus ranging from mild distortions of color and sound to visual hallucinations, dissociative sensations, and loss of motor control.
Other names	Dextromethorphan, dex, robo, skittles, triple C, tussin, DXM
For more information	http://www.erowid.org/general/mentions/2004_times-picayune_dxm.html http://www.erowid.org/chemicals/dxm/dxm_info2.shtml http://www.drugfree.org/Portal/Drug_Guide/DXM http://www.dxmstories.com/about_us.html
Pseudoephedrine/Ephedrine (Stimulant)	
Description	Pseudoephedrine is a decongestant found in over-the-counter tablets and capsules; ephedrine is a commonly used stimulant. Pseudoephedrine is a key ingredient needed for the production of the illicit drug methamphetamine.
Effects	Pseudoephedrine is used to treat congestion associated with allergies, hay fever, sinus irritation, and the common cold.
Other names	Mini thins; Sudafed; trucker's speed
For more information	http://www.drugfree.org/Portal/Drug_Guide/Pseudoephedrine http://www.erowid.org/chemicals/ephedrine/ephedrine.shtml http://www.erowid.org/chemicals/ephedrine/ephedrine_info1.shtml

Contributed by Ernie Chang, Prevention Resource Center Program Specialist

Prescription Drugs

Sedatives and Tranquilizers

Prescribed use	Prescription medications that act as central nervous system depressants. Barbiturates are prescription sedatives or sleeping pills and benzodiazepines are prescription tranquilizers.
Effects	Prescription sedatives and tranquilizers can cause euphoria. They also slow normal brain function, which may result in slurred speech, shallow breathing, sluggishness, fatigue, disorientation and lack of coordination or dilated pupils.
Other names	Mebaral, Quaaludes, Xanax, Valium, Nembutal
For more information	www.drugfree.org/Portal/Drug_Guide/Prescription%20Sedatives% 20and%20Tranquilizers

Opioids

Prescribed use	Post-surgical pain relief, management of acute or chronic pain, relief of coughs or diarrhea
Method(s) of use	Ingestion or injection
Effects	Attach to receptors in the brain and spinal cord, blocking transmission of pain messages to the brain. Short term effects: drowsiness, constipation, depressed respiration. Can cause severe respiratory depression and/or death after a single large dose. Potential for tolerance, physical dependence, withdrawal and/or addiction.
Other names	OxyContin, Darvon, Vicodin, Dilaudid, Demerol, Lomotil

Central Nervous System Depressants

Prescribed use	Relieve anxiety, tension, panic attacks, acute stress reactions, sleep disorders
Effects	Slow brain activity, producing a calming effect. Anastesia. Sleepy and uncoordinated feeling during the first few days as the body becomes accustomed to the effects, but these feelings diminish. Potential for tolerance, physical dependence, withdrawal and/or addiction. Can cause seizures after reduction or disconuation of use.
Other names	Mebaral, Nembutal, Valium, Librium, Xanax, Halcion, ProSom

Stimulants

Prescribed use	Enhance brain activity, causes an increase in alertness, attention and energy.
Effects	Elevated blood pressure, increased heart rate, increased respiration, suppressed appetite, sleep deprivation. Potential for addiction. Dangerously high body temperatures or irregular heartbeat after taking high doses, cardiovascular failure or lethal seizures.
Other names	Dexedrine, Ritalin, Meridia

Source: National Institute of Drug Abuse Research Report Series, Prescription Drugs: Abuse and Addiction. NIH Publication No. 01-4881, 2001.

Reading the Ads: *Media Literacy*

—Jenna Caplette

A couple toasts one another. Behind them, a fire crackles in the hearth, exuding warmth. There is a Christmas tree off to the right, decorated with tiny, sparkling, lights. The glow of the fire and the Christmas lights are caught by the pale, bubbly champagne in the glasses the couple raises to one another. The commercial inspires warm, romantic feelings, and a sense that maybe this kind of celebration is what the holidays are really about.

What is missing from these kinds of visuals is that same couple in the midst of an alcohol-induced argument, and strings of lights that flicker and die. No one wakes sick with a morning-after hang-over. These kinds of ads do exactly what they are designed to do: create a vision, a myth, about the holiday season and the role alcohol plays in the perfect celebration.

Peter DeBenedittis, Ph.D. is an independent speaker and educator on media literacy. He has presented to over 50,000 students and trained thousands of teachers, prevention specialists and health promotion professionals across America, including hundreds here in Montana. What is he training them to do? To look at advertisements and question what they see.

> ***The budget for promoting a national brand of beer can add up to more than the total federal budget for research on alcoholism and alcohol consumption.***
>
> **—Jean Kilbourne, Ph.D**

"Media literacy," Dr. DeBenedittis says, "is the ability to *read* television and movies and to know that the message you are being given has a meaning." He says that for Thanksgiving and Christmas, the alcohol folks try to tell us that celebration means drinking. "Media is a for-profit system, controlled by a handful of corporations, bought and paid for by advertisers. Everything those advertisers do is at the behest of product. Alcohol is the second biggest advertiser nationwide. No one has the kind of money it would take to mount a campaign to counter their claims."

Think about it. Ads at Christmas include soft, romantic music. Beautiful, elegant women. They make the appeal of alcohol "classy," as if this is who you will become if you use it. The truth is, a lot of relationships don't survive the holidays. People often feel lonely at this time of year. The hope is as those people watch these ads they'll think, "Yeah, this is what I need to hold my relationship together, to build a better life, to experience more romance."

DeBenedittis sums up the reality. "Media companies hire teams of psychologists to go over ads. They cater to people's desire to feel part of a family." In fact, those companies spend millions of dollars funding studies of demographics to know what types of people buy a particular product. The shopping cards required by so many grocery stores allow consumers to take advantage of store discounts. They also gather that kind of information.

"Ad companies want, and buy, data," says DeBenedittis. "They need to be able to market to the particular psychological needs of a particular group." The impact of this advertising doesn't just reach adults. College-age, teen, and pre-teen audiences are critically important markets. Young people are making decisions now that may ultimately create a particular brand loyalty, a particular way of drinking. These decisions could lead to lifetime habits.

Alcohol ads imply that drinking is one of the major rites of passage into adulthood. As the holidays approach, says DeBenedittis, teenagers can be "fully aware that their parents and other adults—being full of Christmas cheer—may not be at their most vigilant."

Please make conscious choices about how you celebrate the season. Pay attention to what advertisers say is normal, healthy behavior. Take back your holiday season. Create your own traditions.

—Jenna Caplette is the Prevention Writer for Alcohol and Drug Services of Gallatin County, and marketing consultant for the Montana Alcohol based Health promotions Partnership (MAhP). For more information, visit: www.mapyourcourse.org.

Welcome, Joan Miles

Joan Miles was appointed by Governor Brian Schweitzer as Director of the Montana Department of Public Health and Human Services on September 12, 2005. Prior to her appointment, Miles served with the Lewis and Clark City-County Health Department in Helena for eighteen years, and as Director for the last eleven.

Earlier in her career, she worked as a law clerk for the Montana Supreme Court and served two terms (1984-88) in the Montana Legislature, representing Central Helena.

Miles has a bachelor's degree in medical technology from State University of New York at Albany, a master's degree in Environmental Studies from the University of Montana in Missoula, and a law degree from the University of the Pacific McGeorge School of Law in Sacramento. She is licensed to practice law in Montana and California.

AOD Use and Psychiatric Symptoms

—Mona L. Sumner

With the tremendous gains in brain research, we are able to better pinpoint the relationships between AOD [alcohol and other drugs] use and psychiatric symptoms and disorders. Adolescents are even more vulnerable to the effects of AOD use than adults are.

We used to think the brain was, for the most part, developed by age six. After that, we believed that the brain was simply storing more information as its circumference grew. We now know that the brain is a dynamic, growing organ that is not fully developed until the early twenties. *Any* developing organ can be particularly susceptible to toxic or dangerous stimuli. The most obvious examples can be found in the Fetal Alcohol Spectrum Disorders (FASD). Alcohol seeks fatty tissue. In the fetus, the largest source of fatty tissue is the brain. We now believe that the third trimester is the brain's most vulnerable period to alcohol exposure. Damage can, however, occur at any period.

Marijuana is another example of a substance that can induce psychiatric symptoms and disorders. As the most frequently used illicit drug among teens, there is a great need to understand the impact of this drug on the developing brain. As with alcohol, marijuana seeks fatty tissue and may be stored there for as long as two years. It has the ability to literally clog the neurotransmission system of the brain and in so doing, create significant symptoms of depression. Long-term use is associated with various depressive disorders and requires the use of anti-depressant medications. We have found over many years at Rimrock Foundation that adolescent patients who regularly abuse marijuana, and who earn the diagnostic label cannibus dependence, are generally found to have co-existing depression.

As with any diagnosis, it is important to identify which of the two diagnoses occurred first. This knowledge has implications for the length of time the patient will need medication. A small percentage of adolescents with a substance use disorder and co-occurring depression have had longstanding childhood depression and may be using marijuana or other drugs to self-medicate. This group will likely need antidepressant medication over the course of the lifetime. The larger percentage describe the onset of depressive symptoms following the initiation of substance abuse. Most of these adolescents will admit that they increased their use of pot to mitigate the depressive symptoms, thus initiating a vicious cycle. With abstinence from marijuana, this group will need a 6 to 9 month course of antidepressant medication to rebalance the brain chemistry. Afterward, they may never need medications again, provided they abstain from pot.

The most frequent co-occurring disorders associated with substance use disorders appear to be mood disorders. Given our new-found knowledge of the brain, this is not surprising. Psychoactive substances affect those parts of the brain that control mood. While each class of substances impacts the brain differently, all substances—including alcohol—impact the distribution of dopamine. Dopamine, which produces pleasure, is also the mechanism by which our moods are regulated. The regular use of psychoactive substances generally depletes dopamine, causing various forms of depression. Anxiety is another mood disorder and commonly co-occurs with AOD use. Stimulants and inhalants generally induce anxiety symptoms and disrupt the brain's natural chemistry, which guards against anxious moods.

Over prolonged periods of use and with ingestion of large volumes, alcohol is a culprit in the onset of depression and anxiety. No discussion of the role of AOD use in teens is complete, however, without underscoring that such use can trigger psychotic episodes and symptoms. Methamphetamine is famous for this. AOD use can also hasten the onset of serious mental disorders such as bi-polar and schizophrenia disorders in young people susceptible by virtue of genetics.

Co-occurring mental disorders are yet another reason to treat substance abuse and dependence in teens. The resulting benefit is the potential to prevent significant psychiatric symptoms and disorders.

—Mona L. Sumner is the Chief Operations Officer/Clinical Director for Rimrock Foundation. She is a member of the American College of Addiction Treatment Administrators and the National Association of Addiction Treatment Providers.

PNA Data Bites

The Prevention Needs Assessment (PNA) Survey was last conducted Spring 2004 in grades 8, 10, and 12. The survey has been conducted every other year since 1998 by the Montana Department of Public Health and Human Services, Addictive and Mental Disorders Division, Chemical Dependency Bureau. The survey was designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict these adolescent problem behaviors. In 2004, a statistically valid 18,579 students were surveyed in schools throughout Montana.

Percentage of 12th grade students who used ATODs (Alcohol, Tobacco or Other Drugs) during their lifetimes (2004):

— Alcohol: 84.62%

— Cigarettes: 57.59%

— Chewing tobacco: 31.77%

— Inhalants: 11.48%

— Opiates: 18.98%

Percentage of 10th grade students who used ATODs (Alcohol, Tobacco or Other Drugs) during their lifetimes (2004):

— Alcohol: 73.84%

— Cigarettes: 43.77%

— Chewing tobacco: 22.84%

— Inhalants: 13.02%

— Opiates: 15.81%

Percentage of 8th grade students who used ATODs (Alcohol, Tobacco or Other Drugs) during their lifetimes (2004):

— Alcohol: 54.59%

— Cigarettes: 32.36%

— Chewing tobacco: 11.40%

— Inhalants: 15.49%

— Opiates: 9.73%

The Preventable Birth Defect

—Sandra Van Campen

"We must prevent all injury and illness that is preventable in society, and alcohol-related birth defects are completely preventable," —Dr. Richard Carmona

Alcohol consumption during pregnancy is the leading known cause of birth defects and entirely preventable if pregnant women do not drink.

Fetal Alcohol Syndrome (FAS) is one of the most serious consequences of drinking during pregnancy. It occurs in about 2 of 1,000 live births. This syndrome can include inadequate growth before or after birth, facial defects, a small head, mental retardation, and abnormal behavioral development, as well as a variety of other physical and emotional problems. Fetal Alcohol Spectrum Disorder (FASD) is a term used to describe a range of disabilities. FASD may occur in one percent of births (Sampson, 1997), and covers several alcohol-related medical diagnoses including FAS, partial Fetal Alcohol Syndrome (also called Fetal Alcohol Effect), and alcohol-related birth defects.

Children and adults affected by FASD may have a hard time learning and controlling their behavior. For example, they may appear to learn how to do a task one day, but not remember the next. Other common problems include trouble with reasoning, learning from experience, understanding the consequences of their actions, and getting along with others. These problems can occur even when the individual had no obvious physical birth defects.

Fetal Alcohol Syndrome was officially identified and described in 1973, and we now know even more about the teratogenic effects of alcohol on the developing fetus. Research continues on many questions related to alcohol use in pregnancy. We know that a baby's brain is very sensitive to alcohol while it is developing, but we don't know how much alcohol it takes to cause damage. Research shows that children born to mothers who had as little as one drink per day during pregnancy may have behavior and learning problems (Jacobson, 1999). Binge drinking is especially damaging to the developing baby (Warren, 2001).

Nationally, approximately 10 percent of pregnant women reported alcohol use in 2003, with four percent reporting binge drinking (National Survey on Drug Use and Health, 2003). In Montana, an estimated 21 children are born each year with FAS, and 87 are born with alcohol-related birth defects. The cost to the state of caring for children and adults affected by FAS and Fetal Alcohol Spectrum Disorders (FASD) is around $24 million a year. (www.dphhs.mt.gov/newsevents/newsreleases 2004/september/fetalalcholol awareness)

The CDC's 2001 Youth Risk Behavior Survey indicated that almost 83 percent of female adolescents in Montana drink alcohol and 39.3 percent drink more than five drinks per episode (binge drinking). Since studies indicate that 78 percent of adolescent pregnancies are unplanned (AGI, 1999), this equates to significant risk for alcohol-exposed pregnancies. Women with unplanned pregnancies frequently report alcohol consumption prior to discovering they were pregnant.

The Department of Public Health and Human Services (DPHHS) was recently awarded a Northrop Grumman/SAMHSA subcontract to implement an intervention program for the prevention of FASD. A portion of the $325,000 award will be used to add paraprofessional home visitors to between six and eight Public Health Home Visiting (PHHV) teams in Montana during the next year. The subcontract will be administered by the Child, Adolescent, and Community Health section of the Public Health and Safety Division.

Currently, 16 county and tribal health departments have PHHV teams that provide home-visiting support and case management to high-risk pregnant women and high risk infants. The teams are comprised of a registered nurse, a social worker and a dietitian. The addition of a lay home visitor will provide more intense case management and home visiting services for those who are at the greatest risk of using alcohol during their pregnancies.

The focus of the home visits is not simply to reduce alcohol and drug use, but to reduce other risk factors and behaviors as well.

—Sandra Van Campen is a Perinatal Abuse Prevention Consultant with the Montana Department of Public Health and Human Services. She can be reached at (406) 444-0041.

PNA Data Bites 2004

Percentage of 12th grade students who used ATODs (Alcohol, Tobacco or Other Drugs) during the past 30 days (2004):

- *—Alcohol: 60.46%*
- *—Cigarettes: 28.14%*
- *—Chewing tobacco: 14.15%*
- *—Inhalants: 1.72%*
- *—Opiates: 8.18%*

Percentage of 10th grade students who used ATODs (Alcohol, Tobacco or Other Drugs) during the past 30 days (2004):

- *—Alcohol: 46.18%*
- *—Cigarettes: 18.74%*
- *—Chewing tobacco: 9.87%*
- *—Inhalants: 3.10%*
- *—Opiates: 7.13%*

Percentage of 8th grade students who used ATODs (Alcohol, Tobacco or Other Drugs) during the past 30 days (2004):

- *—Alcohol: 24.16%*
- *—Cigarettes: 10.78%*
- *—Chewing tobacco: 3.94%*
- *—Inhalants: 5.41%*
- *—Opiates: 4.28%*

Percentage of students with heavy use of alcohol and cigarettes (2004):

Binge Drinking (more than 5 drinks on one occasion)

- *—Grade 12: 44.40%*
- *—Grade 10: 32.26%*
- *—Grade 8: 16.23%*

Pack of cigarettes per day

- *—Grade 12: 2.93*
- *—Grade 10: 1.15*
- *—Grade 8: 0.43*

Traffic Safety and Teens

—Pamela R. Buckman, Montana State Highway Traffice Safety Office

It was a beautiful, warm autumn evening. Everyone was cruising around, honking and waving at friends in celebration of winning the cross-town football game. One group of teenagers decided to indulge in some alcohol and head for the back roads in a topless Jeep. Who cares that they aren't 21, who *cares* that they aren't properly restrained? This was a night to celebrate. Unfortunately, after the Jeep rolled, one teenager would never celebrate again. What a senseless tragedy!

— In 2004, 499 Montana teenage drivers were involved in alcohol/drug related crashes and of those, 17 were fatalities.

— Throughout the country, alcohol is a factor in more than 1/3 of the teenage motor vehicle fatalities.

— Lack of proper safety restraints and/or motorcycle helmets is a factor in more than 2/3 of teen motor vehicle fatalities.

Disturbingly, this scenario is not uncommon. Motor vehicle crashes are the number-one killer of young adults between the ages of 16 and 20.

Teenagers, by definition, are rebellious. They contend that they should be allowed to drink at age 18 when they are legally "adults." But according to a national survey conducted by the National Highway Traffic Safety Administration, they don't just sip or consume moderately, they guzzle or gulp alcoholic beverages and proceed to cruise around with friends.

The challenge is to firmly establish lawful traffic safety behaviors in teens' everyday lives. The Highway Traffic Safety Office has funded numerous public information and educational materials targeted at teenagers and geared to encouraging them not to drink . . . and especially not to drink and drive. There are also materials encouraging them to wear seatbelts and motorcycle helmets. *Healthy Mothers, Healthy Babies* and *Safe Kids Safe Community* coalitions throughout the state distribute educational brochures to high schools; conduct alcohol sales and underage drinking laws seminars for merchants and solicit high school students' assistance conducting seat belt surveys.

The State Highway Traffic Safety Office helps support a grant with the Office of Public Instruction and the Montana Board of Crime Control to conduct the Montana Youth Risk Behavior Survey. Through analysis and evaluation of the final product, Montana school systems can target academic curriculums to accommodate changing teenage risk behaviors.

The Graduated Drivers License law takes effect July 1, 2006. Its philosophy and process should have a noticeably positive impact on Montana's newest drivers. Finally, the Primary Seat Belt Law will come up in the 2007 Legislative Session. Statistics in states that have a primary seat belt law claim that 70 percent of those involved in motor vehicle crashes while wearing seatbelts survive. Montana is long overdue in enacting this legislation. Countless lives are being lost in the interim.

Changing teenager's potentially fatal traffic behaviors is everyone's responsibility. Parents, teachers, role models and public officials should lead by example. Buckle up, wear a motorcycle helmet and above all—don't drink and drive!

Department of Revenue administrative penalties assessed to alcohol licensee selling to a minor:

— 1st offense: $250.00

— 2nd offense: $1000.00

— 3rd offense: $1500.00 plus 20 day suspension

— 4th offense: revocation

Montana Code Annotated and Current Legislation

The following MCA and legislation addresses sales to youth, consumption of alcohol by minors, and penalties.

— 6-3-301. Unlawful purchases, transfers, sales or deliveries-presumption of legal age.

— 16-6-304. Providing alcoholic beverages to intoxicated person prohibited.

—16-6-305 Age limit for sale or provision of alcoholic beverages-liability of provider.

— 45-5-622 (2)(a)(i). Endangering the welfare of children.

— 45-5-623. Unlawful transaction with children.

— 45-5-624. Unlawful attempt to purchase or possession of an intoxicating substance-interference with sentence or court order.

— Senate Bill 407—An act revising the minor in possession law: and smending section 45-5-624 MCA. (Effective date October 1, 2005)

— House Bill 348—An act restricting youth access to alcohol and providing for registration of sales of kegs of beer. (Effective date October 1, 2005)

For more information on the new Open Container Law, visit: www.mdt.mt.gov/publications/docs/brochures/safety/open_container.pdf

Montana's EUDL

The goal of the Enforcing Underage Drinking programs (EUDL) is to support and enhance state and local efforts to enforce laws prohibiting the sale of alcoholic beverages to, or the consumption of alcoholic beverages by, minors. For the purposes of this program, minors are defined as individuals under 21 years of age. Some of the activities that fall within the purview of the EUDL include task force activities that target establishments suspected of violating state laws governing sale to and consumption of alcohol by minors, public advertising campaigns, and programs designed to prevent and combat underage drinking.

The EUDL grant focuses on the community domain of risk factors, including community laws and norms favorable toward drug use, firearms and crime. The grant is targeted to the reduction of favorable norms and increasing protective factors that include healthy beliefs and clear standards.

The Montana Board of Crime Control is the administrative agency for the Statewide Enforcing Underage Drinking Laws Program, and passes the funding through on a competitive basis to subgrantees throughout the state. For more information, contact EUDL Coordinator Patti Jacques 406-444-2056 or by email at pjacques@mt.gov.

Gear Up, Montana

Montana has been awarded a six-year, $18 million GEAR UP (Gaining Early Awareness and Readiness for Undergraduate Programs) grant to increase the number of low-income students prepared to enter and succeed in postsecondary education. This is Montana's second GEAR UP grant, and it helps support the state's commitment to ensuring access for all postsecondary education and strong collaboration between K-12 and higher education.

Montana GEAR UP believes that postsecondary education is possible for all Montana students, regardless of economic background, and strives to empower them to realize that ambition. Montana GEAR UP brings this message to middle and high schools, students, parents, and the community through early college and career awareness activities, scholarships, financial aid information, and improved academic support to help raise the expectations and achievement of all. In 2005 alone, Montana GEAR UP awarded 17 scholarships, valued at up to $20,000 each, to graduating seniors, as well as $1,000 Achievement Grants to 292 high school juniors for postsecondary education in Montana. Montana GEAR UP will work with 24 middle schools qualified to participate based on their student participation in the federal Free and Reduced Lunch Program.

> ***Education is a ticket out of poverty, said Governor Schweitzer. GEAR UP will offer many of our most vulnerable students a ticket to graduate from high school—and make the dream of going on to college a reality.***
>
> **—Governor Brian Schweitzer**

Montana GEAR UP uses a cohort model, providing early college and career awareness services, such as tutoring, mentoring, and college visits, to an entire class of students beginning in the seventh grade. The program continues to serve those students as they progress through middle and high school. Each year of the grant, a new class of 7th graders is added. By the sixth year of the grant, Montana GEAR UP will provide services to all 7th through 12th grade students in the 24 GEAR UP schools and their receiving high schools—an estimated 4,900 students.

For more information, visit: www.gearup.montana.edu.

Best Practice Sources

Montana uses numerous guidance materials and activities through the Underage Drinking Enforcement Training Center – Pacific Institute for Research and Evaluation. Regulatory Strategies for Prevention Youth Access to Alcohol: Best Practices, discusses strategies and implementation. It breaks into three categories: Commercial Availability, Social/Public Availability, and Youth Possession. For more information, visit: www.udetc.org/Publications.htm.

Teens and Cigarettes

A survey by the Center on Addiction and Substance Abuse (CASA) and the American Legacy Foundation found that marijuana is pervasive in the life of a teenage cigarette smoker. Teens who smoke nicotine cigarettes are 14 times likelier to try marijuana, six times likelier to be able to buy marijuana in an hour or less and 18 times likelier to report that most of their friends smoke marijuana. Among teens who are repeat marijuana users, 60 percent tried cigarettes first. The findings indicate that reducing teen smoking can be a singularly effective way to reduce teen marijuana

Report on Teen Cigarette Smoking and Marijuana Use by the National Center on Addiction and Substance Abuse at Columbia University (September 2003). This report and others can be located at http://www.casacolumbia.org

Prevention Works: *the Flagship Program*

—Rosie Buzzas

Tobacco and Montana's Youth

— 23% of Montana high school students reported current cigarette smoking.

— 13% of Montana 7th and 8th grade students reported current cigarette smoking.

— Campaign for Tobacco Free Kids estimates that Montana kids buy or smoke about 3.9 million packs of cigarettes each year.

— Almost 90% of adult smokers began at or before age 18.

— 20% of Montana high school boys use chew or spit tobacco. Spit tobacco users are up to 50 times more likely to get oral cancer than non-users.

— Chew can be more addictive than cigarettes because it contains more nicotine. One can of chew delivers as much nicotine as 60 cigarettes.

Sources: Montana Tobacco Use Prevention Program, www.dphhs.mt.gov/PHSD/Tobacco

This project is a wonderful example of successful collaboration in Montana. The initial "seed" money was made available through the Interagency Coordinating Council (ICC), and many PRC VISTAs contributed their time and talents to the project. These resources enabled the community to leverage other resources to set the foundation for the program.

Prevention works! No matter which of the six Center for Substance Abuse Prevention (CSAP) strategies is used—Information Dissemination, Education, Community-based Process, Alternatives, Environmental or Problem Identification and Referral—there is research and best practices that prove these approaches are successful. The efficacy of preventing high-risk behaviors (including substance abuse, school failure/dropout, sexual activity/teen pregnancy, violent behavior) has over 30 years of research behind it (Catalano & Hawkins). So does our knowledge of protective factors that help young people become resilient to engaging in high-risk behaviors.

Effective prevention programs incorporate best practices and adapt research-based strategies. For example, we know that a positive relationship with a significant adult is a proven prevention factor for young people at high risk of engaging in risk behaviors. Research also tells us that the after-school hours—from 3-6 P.M.—are when most high-risk youth behaviors occur.

Missoula's Flagship Program is an after-school and summer program that provides skill-building opportunities for young people in grades K-12 in nine of Missoula's District One public schools. It is a universal strategy, targeting all kids in the school attendance area. It is also selective, in that it seeks to include those students considered to be at-risk or high-risk. In terms of CSAP strategies, the program is considered an "alternative activity." Flagship activities are provided free of charge to students.

The Flagship Program is a community-school partnership. Flagship provides staff, food, supplies for activities and transportation for each of nine school sites. The school district provides office space and supplies, and keeps the schools open during non-school hours for activities. Flagship is built on a broad-based collaboration of existing community resources—over 25 current partner organizations—that bring their programs to the schools, where the kids are.

Flagship's mission is to enhance the academic, social and cultural development of young people with the goal of helping them be successful in school and resilient to risk behaviors. The program is based on prevention research and best practices and includes mentoring, youth development activities, skill-building classes, service learning and community volunteer opportunities.

Flagship serves an average of 4,000 youths per year, providing over 500 different activities. An average of 500 student, community, and university volunteers donate nearly 7,000 hours of their time in association with Flagship activities each year.

The effectiveness of Flagship is measured with a variety of tools and methods. Montana's Prevention Needs Assessment (PNA) survey is administered to students in grades 8,10 and 12 every other year, in even numbered years. In tracking those results, we have seen positive changes over time, particularly at Porter Middle School where Flagship has nine years of history.

Sections of the PNA are also administered annually at all of our middle and high school sites. Flagship has established a standard database that collects data from each school site on attendance, student contact hours, volunteers, volunteer hours, donations and demographic information on participants. Anecdotal data, including student, parent and teacher feedback and stories is also collected.

Flagship has participated in two national evaluations on Promising After-School Programs. The most recent was sponsored by the Mott Foundation and conducted by Policy Studies Associates, Inc. and the University of Wisconsin. That two-year study was completed in June 2005. The results have not yet been published.

An earlier study sponsored by the Wallace Reader's Digest Funds was conducted by Public/Private Ventures and

Continued on Page 21

The Flagship Program

Continued from Page 20

Manpower Development Resource Corporation between 1998 and 2001. The Flagship Program was one of 21 intensive study sites nationwide. Results showed that students who participated in the school-based after-school programs experienced positive change in four key areas; staying out of trouble, improving school attitudes and behaviors, strengthening social networks and learning new skills, seeing new possibilities and improving their self-confidence. Additionally, 9 percent of the after-school program participants reported they had started drinking alcohol over the research period, compared to 16 percent of their peers who did not attend the program.

The Flagship Program is funded through a variety of public and private sources. Some factors that have led to secured funding include a strong local base, measuring success through the PNA and other evaluation tools, and maintaining a quality program. Private and federal funders look at local match as a positive sign that the community supports the program. Local funders like the idea that Flagship can leverage additional dollars with the money they provide.

The Flagship Program is part of a larger community prevention effort. Missoula has a prevention coalition called the Missoula Forum for Children and Youth. One of the subgroups of the Forum is MUSAP (Missoula Underage Substance Abuse Prevention). MUSAP works on environmental strategies such as changing community norms by providing public education and targeted strategies for specific populations groups (parents, community and age-specific young people). Other subgroups include: Healthy Start, Youth Development Network, and the Media Literacy. All are working on strategies to engage the community in helping young people grow into healthy adults. Flagship works in concert with these groups and is an important piece of the Forum's work. In fact, Flagship was created in response to the early work of the Forum as a strategy to provide direct prevention services to youth.

The field of substance abuse prevention is not just a feel-good, *just say no* approach. It is science-based and tied to many best practice strategies that meet tough criteria proving cause and effect. *Prevention works!* And it's our job, as prevention workers to convince funders, policy makers and community members that the resources they invest in research-based prevention programs pay off in the long run.

—Rosie Buzzas is a Social Worker who has served as director of the Flagship Program since 1997. Flagship is a program of Turning Point/Western Montana Addiction Services, Inc. She is also a four-term legislator in the Montana House of Representatives, representing HD 93. For more information, contact rbuzzas@wmmhc.org.

The Willard Street Project

—Rosie Buzzas

Willard Alternative High School was opened by Missoula County Public Schools in 2001 to serve a group of high school students identified as high risk for dropout due to histories that included academic failure, chronic absenteeism, and factors including substance use and involvement with the judicial system. It accepts a maximum of 150 students per year. The *Willard Project* is in its fifth year of operation, with the goal of reducing violence, alcohol and drug use through comprehensive community-based prevention. The project integrates a variety of educational, vocational and community services for students.

Approximately 15 – 20 skill-building activities are offered through the Willard Project each semester. These include service learning, tutoring/mentoring, outdoor recreational opportunities, arts classes, community volunteer and independent learning opportunities tailored to individual students.

The strategies and model used by the Willard Project were already in place in other schools in Missoula, and are known as the Flagship Program. The goal of Flagship is to provide youth development activities as an alternative to substance use and other high-risk behaviors among young people. The program is based on the risk and resiliency research of Catalano and Hawkins. Flagship is a community-school partnership that brings opportunities to students in order to enhance their social, academic and cultural development. Flagship operates at eight school sites in Missoula, primarily through a variety of non-school-hour activities. It was apparent from the population served by the Willard School that the model would have to be adapted to be more integrated with the school day.

Did you know?

- *34% of Montana high school students reported that within the 30 days prior to the survey, they had ridden in a car driven by someone who had been drinking.*
- *19% of Montana high school students reported that within the 30 days prior to the survey, they had driven a car after drinking alcohol.*
- *In 2001, 51% percent of highway fatalities involving Montana youth (ages 15 – 20) were alcohol related, versus a national average of 38.1%.*
- *34% of Montana high school students reported that they had five or more drinks in a row at least once during the past 30 days.*
- *12% of the Montana 7th and 8th grade students surveyed reported that they'd had five or more drinks in a row at least once during the past 30 days.*

Source: Youth Risk Behavior Survey, 2005

Montana Cancer Control Coalition

—Lieutenant Governor John Bohlinger

A diagnosis of cancer scared the hell out of me! Having lost both of my parents to cancer, I thought I was genetically flawed when I got my own diagnosis of prostate cancer eight years ago. Thankfully, my treatments went well and I remain cancer-free today.

Last November, cancer entered my life again. My wife, Bette, was diagnosed with acute myeloid leukemia. After a considerable ordeal, the disease is now in remission and she's getting better and stronger every day. We both remain indebted to the numerous physicians, nurses, friends and family who helped us through our mutual journeys to recovery.

As I have learned firsthand, significant progress has been made in improving cancer prevention, early detection, treatment, quality of life and survivability. Yet, despite these many advances, cancer continues to cause too much death and heartache in Montana.

Cancer is the second leading cause of death in our state, taking the lives of over 1,800 Montanans each year. Annually an estimated 5,000 new cancer cases will be diagnosed in Montana and the economic burden will exceed $588 million. Certainly, there is more that can be done to prevent and control cancer in our state.

In fact, more is being done. The Montana Cancer Control Coalition—a group of cancer survivors, caregivers, medical professionals, hospital administrators, representatives of nonprofits, state agencies, legislators, organizations and others—has recently released a draft Comprehensive Cancer Control Plan for the State of Montana. This comprehensive approach to cancer control is an emerging nationwide strategy that the Coalition has adopted to help ensure that all of our state's cancer-controlling resources—from government programs to private organizations—are working together in every community and on all fronts.

I am greatly enthused about the draft Comprehensive Cancer Control Plan and the work of the Montana Cancer Control Coalition. I encourage all citizens to participate in shaping and advancing the future of cancer prevention and control in our state and to join in the effort of creating a healthier Montana. Cancer has had an impact on Montanans for long enough. It's time we had an impact on it.

Please visit the Coalition's web site and learn more about the plan: www.cancer.mt.gov. For more information or to order printed copies, call 406-444-3624.

– John Bohlinger is a veteran of the Montana legislature. First elected in 1992, John was elected to three terms in the house and recently resigned his seat in the Senate to serve as Lt. Governor in January 2005. On November 2, 2004, John Bohlinger was elected as Montana's Lieutenant Governor.

Tobacco and Montana's Health

— The Campaign for Tobacco Free Kids estimates that more Montanans die each year from smoking than from car accidents, alcohol, drugs, AIDS, suicide, and murders combined. Tobacco use is also the single most preventable cause of death and disease in our society.

— On an average day, nearly four Montanans die prematurely from smoking-related diseases. That's more than 1,400 annually.

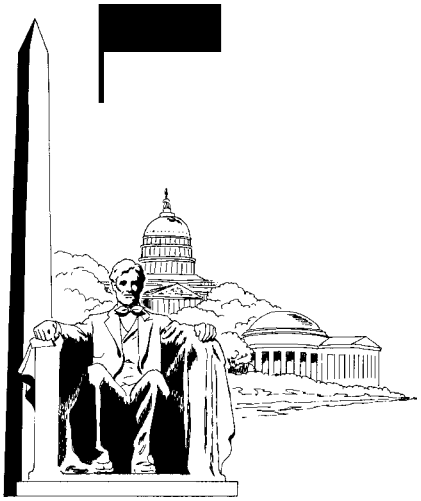
— Secondhand smoke kills approximately 110—200 Montanans yearly. Surveys show one out of four Montana homes have been smoked in recently, and children lived in 35% of those homes.

— Tobacco-related health care costs in Montana total over $216 million per year.

Source: Montana Tobacco Use Prevention Program, www.dphhs.mt.gov/phsd/tobacco

The DC Connection
Girls and Alcohol

—Theresa Racicot



Why are our young daughters and granddaughters at increasing risk of harm by alcohol use? Until recently, boys were more likely to use alcohol than girls. Prior to 2002, girls reported consuming alcohol at rates less than or equal to the rate of boys; recently however, 38.5 percent of ninth-grade girls reported drinking in the last month versus 34 percent of boys. The drinking behavior has changed as well: 20.9 percent of girls and 18.8 percent of boys reported binge drinking—aggressive alcohol use that quickly puts the drinker at risk[1]. What has brought about this change and what does this mean for Montana's young girls? How can we safeguard our youth against the dangers of underage alcohol use?

The 2003 Youth Risk Behavior Survey for Montana shows just how alike girls and boys are in the use of alcohol.

— 49.6% of male and 48.9% of female respondents in grades 9-12 reported that they "had at least one drink of alcohol on one or more of the past 30 days"[2].

— 37.0% percent of male and 36.4% of female respondents reported that they "rode one or more times in a car or other vehicle driven by someone who had been drinking alcohol in the past 30 days[3]."

Several theories are emerging to explain the rise in alcohol use by girls. One is that young girls often have more spending money than their male counterparts, enabling them to purchase alcohol more easily. Another theory suggests that young women endure higher stress levels than boys and use alcohol as a means of managing that stress. Many teenage girls report using alcohol as a short-lived escape: alcohol fuels the illusion of confidence and control at a time in girls' lives when self-image and self-esteem are at a low.

While underage alcohol use is dangerous for both boys and girls, it is likely that girls are more sensitive than boys to alcohol's effects. Studies of adult women show increased risk due to different metabolism rates, lower body weights, and the particular way in which the female body processes alcohol. Not only does alcohol affect menstruation and fertility, women are more susceptible to alcohol poisoning, liver disease, heart disease, and hepatitis B.

With alcohol sales and advertising pervading our communities, dominating many of our athletic, cultural and community events, alcohol has become a normalized presence in our children's lives. Boys and girls today live in a world saturated by images of alcohol and powerful messages of what alcohol might offer the drinker. It is estimated that underage girls saw 95 percent more advertising for "malternative" or "alcopop" drinks than legal-age women, while boys saw 37 percent more ads than legal-age men[4].

Alcohol ads depict people having a great time. The ads are sexy, seductive, and many suggest that the use of their product brings empowerment and liberation. The women in most alcohol ads are beautiful, self confident, and seemingly in control. As tag lines get more edgy, suggesting that only bad girls are desirable, ads may increase the pressure girls already report they feel to have sex. While alcohol advertising suggests that drinking enhances one's virility, social likeability, prestige, sophistication, success, athleticism and sexual desirability, in reality, alcohol use can destroy these things.

What can we do? First, we need to acknowledge that the culture in which many of our daughters and granddaughters are growing up is one that is highly stressful. Understanding the pressures they face is a critical step in helping girls find healthy ways to manage their feelings. Encourage activities that help girls build self esteem and confidence. Engage them in dialogue about the advertisements they see, the messages they receive from their peers, adults, and the media. Educate children about the dangers of alcohol use and the negative promise it holds for their developing bodies and minds.

It is our responsibility as adults to prepare children for the future. With our help, boys and girls can realize how alcohol distorts reality, and resist the temptation to drink before they reach the legal age. Responsibility for the health of America's children lies with all of us. Parents cannot solve this problem alone, but together we can all make a difference.

—Theresa Racicot is a former First Lady of Montana, and the Emeritus Group Co-Chair for the national Leadership to Keep Children Alcohol Free, a unique coalition of governors' spouses, federal agencies, and public and private organizations. For more information, visit: www.alcoholfreechildren.org/.

1 Centers for Disease Control and Prevention. 2004. Youth Risk Behavior Surveillance United States, 2003. Morbidity and Mortality Weekly Report: CDC Surveillance Summaries 53 (SS-2): 1-96.

2 Montana Office of Public Instruction Health Enhancement Division, 2003 Youth Risk Behavior Survey, Gender Comparison. February 2004

3 Montana Office of Public Instruction Health Enhancement Division, 2003 Youth Risk Behavior Survey, Gender Comparison. February 2004.

4 Jernigan DH, Ostroff J, Ross C, and O'Hara JA. 2004. Sex differences in adolescent exposure to alcohol advertising in magazines. Archives of Pediatrics and Adolescent Medicine 258(7):629-634.

The Last Word

—Joan Cassidy, Chief Chemical Dependency Bureau

Alcohol use has been—and continues to be—a serious issue for Montana youth, families and communities. Despite the high-profile devastation methamphetamine is inflicting on Montana, the number of people struggling with alcohol continues to be much greater. During State Fiscal Year 2004, the numbers of adults (age 18+) served by the community-based, publicly funded system for whom alcohol was the primary drug of addiction was more than four times the number for whom methamphetamine was the primary drug.

Science-based research reveals a strong association between the age a person first uses alcohol and alcohol problems later in life. The National Survey on Drug Use and Health (NSDUH) asks persons aged 12 or older to report on their age at first use of alcohol, their use of alcohol during the past year and in the past month, and their symptoms of alcohol dependence or abuse during the past year. Survey respondents who reported first use of alcohol before age 15 were five times as likely to report past-year alcohol dependence or than those who first used alcohol at age 21 or beyond. Additionally, among the 14 million adults aged 21 or older who were classified as having past year alcohol dependence or abuse, more than 13 million (95 percent) had started using alcohol before age 21. (NSDUH: 2004).

Primary drugs of addiction among those served by Montana's publicly funded treatment system in FY2004:

- ***— alcohol (62.9%);***
- ***— methamphetamine (14.9%); and***
- ***— marijuana/hashish (14.1%).***

Primary drugs of addiction among youth served by the publicly funded treatment system in FY2004 were:

- ***— marijuana/hashish (56.1%);***
- ***— alcohol (31.5%); and***
- ***— methamphetamine (6.9%).***

Data source: Alcohol and Drug Information System (ADIS), 2004

As discussed throughout this issue of the *Prevention Connection*, alcohol is not the only substance being abused by youth. Tobacco often serves as a gateway, and is highly addictive in and of itself. Inhalants and the inappropriate use of over-the-counter medications are both concerns.

Young people use substances to seek euphoria, excitement, sedation, new experiences . . . or they may be succombing to peer pressure, curiosity or ready availability of substances. No matter what their reasons, it is our job—as parents, teachers, counselors, community members—to do everything within our power to offer healthy alternatives, to use the science-based tools at our command, and to shepherd our youth through vigilance and active involvement.

Note: National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by the Substance Abuse & Mental Health Services Administration (SAMHSA). http://www.oas.samhsa.gov.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

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Montana Prevention Resource Center
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